

PART He-M 426 COMMUNITY MENTAL HEALTH SERVICES

Statutory Authority: RSA 135-C:5, I; 135-C:61, III and XII

Readopt He-M 426.01, effective 9-30-08 (Document #9285), to read as follows:

He-M 426.01 Purpose. The purpose of these rules is to describe the services provided by CMHPs and community mental health providers that are offered to persons eligible for services pursuant to He-M 401 and are reimbursable under the medicaid program.

Readopt He-M 426.03 through He-M 426.11, effective 9-30-08 (Document #9285), to read as follows:

He-M 426.03 Recipient Eligibility. All medicaid recipients who are not residents of an IMD shall be eligible to receive the services of CMHPs and community mental health providers when services are delivered in accordance with an ISP.

He-M 426.04 Community Mental Health Providers.

(a) Community mental health providers approved prior to August 22, 1997 shall be authorized to continue to provide medicaid funded mental health services until the date of expiration of provider status as long as the provider:

- (1) Is in compliance with applicable rules;
- (2) Maintains an interagency agreement with the regional CMHP which shall describe:
 - a. Methods for collaborative service planning and service delivery, including joint development and approval of an ISP for each community mental health provider client;
 - b. Service planning which includes the client's family members and other persons significant to the client, to the extent that the client wishes such persons to be involved;
 - c. Service linkages so there is continuity of care between the community mental health provider and CMHP with minimal resource duplication; and
 - d. Provision of 24 hour emergency services, which:
 1. Are contracted or provided directly by the community mental health provider or CMHP; and
 2. Include contingency plans for each client of the community mental health provider; and
- (3) Maintains a quality assurance plan which shall:
 - a. Include quality assurance indicators to identify problems that impact directly or indirectly on clients or on areas which influence client care;

- b. Provide for the development and monitoring of corrective action plans to correct identified problems or deficiencies, where such plans specify time frames and persons responsible for corrective action;
- c. Specify how quality assurance findings are utilized in staff development and annual staff evaluations; and
- d. Allow the department to conduct announced or unannounced quality assurance reviews of the community mental health providers to assure that such services and programs are operated in accordance with the department's rules, contract provisions, and the federally approved state plan mandated by Public Law 106-310.

(b) Only CMHPs or their subcontractors shall be authorized to provide the medicaid funded community mental health services described in these rules.

He-M 426.05 Provider Participation.

(a) Providers of services shall provide sufficient privacy to maintain confidentiality of communication between recipient and staff members.

(b) CMHPs shall be staffed by a multidisciplinary team consisting of licensed practitioners of the healing arts in:

- (1) Psychiatry;
- (2) Psychology;
- (3) Psychiatric social work;
- (4) Psychiatric nursing; and
- (5) Mental health counseling.

(c) CMHPs shall have as a medical director a psychiatrist who is either board certified or eligible for application for certification according to the most recent regulations of the American Board of Psychiatry and Neurology, Inc., or its successor organization, to assume medical responsibility for all clinical diagnoses and treatment programs. The medical director shall be at the CMHP a minimum of 20 hours per week.

(d) Services offered by CMHPs shall be overseen by a psychiatrist responsible for the client's care as documented in the ISP.

(e) An M.D. or ARNP enrolled in a residency training program in psychiatry from a college or university accredited by an accrediting agency recognized by the U.S. Department of Education shall deliver services in accordance with his or her specific board of licensure.

(f) Providers of community mental health services shall have multidisciplinary staff conferences pursuant to He-M 401.10 to review the progress of current cases. Each CMHP shall have a quality assurance program including utilization and peer review to evaluate the effectiveness of covered services as contained in He-M 426.04.

He-M 426.06 Provider Limitations.

(a) The services listed in He-M 426.07 - He-M 426.16 shall be covered services, available under the medicaid program to all eligible medicaid recipients when provided by, or recommended by, a licensed practitioner of the healing arts pursuant to these rules. Services identified in He-M 426.07 - He-M 426.16 may be provided by CMHPs. Community mental health providers shall only provide those services identified in He-M 426.07 - He-M 426.16 for which they have received approval pursuant to He-M 426.04.

(b) Services provided in an inpatient hospital setting shall only be reimbursable through medicaid if provided by a legally qualified psychiatrist. Services provided in an IMD shall not be reimbursable.

(c) Services recommended by a licensed practitioner of the healing arts shall be provided in accordance with department rules and state law.

He-M 426.07 Medication-Related Services.

(a) Administration of medication by injection shall:

(1) Be a covered CMHP service;

(2) Be performed by a physician, physician assistant, registered nurse, or licensed practical nurse licensed to practice in New Hampshire; and

(3) Include administering intramuscular medication required for the treatment of a recipient's mental illness.

(b) The service outlined in (a) above shall not include administration of oral medication, or medical analysis and review performed pursuant to a medication check. Administration of medication by injection and medication check may be billed, using the respective billing codes, as part of the same visit.

(c) Nursing assessment and evaluation for the purpose of reviewing medication compliance, education and symptomatology shall be a covered service when provided by a registered nurse or licensed practical nurse. There shall be no more than one procedure billed per recipient per day.

(d) Brief office visit shall be a covered service when conducted for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic or personality disorders by physicians, physician assistants or ARNPs within the purview of their respective professions. This service shall be billed in accordance with current procedural terminology.

(e) Pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy conducted by physicians, physician assistants, or ARNPs within the purview of their respective professions shall be a covered service.

(f) Brief office visits, nursing assessment and evaluation, or pharmacologic management shall not be billed for recipients on days during which the recipient is in attendance at a partial hospitalization program. A nurse assessment and evaluation shall not be billable on the same day as a medication check.

(g) Comprehensive medication service for clozapine/clozaril management shall be a covered service provided by a physician, physician assistant, ARNP, registered nurse or licensed practical nurse within the purview of their respective profession to prescribe, monitor the effects of, review, or adjust

prescribed clozapine/clozaril. Treatment may be provided up to a maximum of once per day, when a documented drop in the client's white blood cell count (WBC) occurs.

(h) Comprehensive medication service for clozapine/clozaril management shall include the following:

- (1) Ensuring that the required blood sample is drawn;
- (2) Ensuring that the WBC is within established limits;
- (3) Recording the WBC;
- (4) Sending the results of the WBC to the prescribed clozapine/clozaril monitoring system;
- (5) Writing the prescription for clozapine/clozaril as appropriate;
- (6) Ensuring that the client is provided with a supply of clozapine/clozaril as appropriate; and
- (7) Signature by a physician, physician assistant, or ARNP.

(i) Medication services described in (c) through (f) above shall be limited to one service per day and shall not be billed on the same day as any other service described in (c) through (f) above.

He-M 426.08 Psychotherapeutic Services.

(a) Individual psychotherapy shall:

- (1) Be a covered CMHP service;
- (2) Include therapy, crisis intervention, or assessment and monitoring necessary to determine the course and progress of therapy or to stabilize a client experiencing an acute psychiatric episode; and
- (3) Be verbal, with the therapist in direct, personal, involvement with the recipient to the exclusion of other recipients, individuals, and duties.

(b) Individual psychotherapy shall be billed in accordance with current procedural terminology. Individual therapy with medication management shall be billed as one procedure when delivered during the same visit.

(c) Group psychotherapy per person shall:

- (1) Be a covered CMHP service; and
- (2) Be therapy, or assessment and monitoring necessary to determine the course and progress of therapy, that is performed in a direct, personal, involvement with the recipient in a setting with other recipients or clients.

(d) Group psychotherapy shall be billed in accordance with current procedural terminology.

(e) Group psychotherapy shall meet the following criteria:

- (1) A minimum of 2 unrelated recipients and a maximum of 10 recipients shall be in attendance to constitute a group;
- (2) Sessions shall be scheduled often enough to provide effective treatment consistent with the ISP;
- (3) The group focus shall be face-to-face dialogue of a verbal rather than performance nature; and
- (4) Individual progress notes for each session shall be recorded in each recipient's record with specific attention directed toward goal achievement as stated in the recipient's ISP.

(f) Family therapy shall be:

- (1) A covered service; and
- (2) Psychotherapy with:
 - a. The primary identified recipient and that recipient's natural or surrogate family member(s); or
 - b. The natural or surrogate family member(s) without the recipient present.

(g) Billing for family therapy shall be as follows:

- (1) Only one family member's medicaid identification number shall be billed regardless of the eligibility of other members or their inclusion in the problem;
- (2) If a child who has been determined eligible for services pursuant to He-M 401.06 is the primary reason for the family to be receiving therapy, then that child's medicaid identification number shall be used when billing for services;
- (3) If the primary recipient is not present but continues to be the focus of the therapy, that recipient's medicaid identification number shall be used when billing for services and the reason why the recipient was not present shall be documented; and
- (4) This procedure shall be billed in accordance with current procedural terminology.

(h) For the purpose of providing psychotherapy without supervision, clinical staff of CMHPs or providers shall meet the applicable following minimum qualifications:

- (1) Psychiatrists shall meet the requirements of RSA 135-C:2, XIII;
- (2) Psychologists shall be licensed in accordance with RSA 330-A:16;
- (3) Pastoral psychotherapists shall be licensed in accordance with RSA 330-A:17;
- (4) Marriage and family therapists shall be licensed in accordance with RSA 330-A:21;
- (5) Clinical mental health counselors shall be licensed in accordance with RSA 330-A:19;

(6) Clinical social workers shall be licensed in accordance with RSA 330-A:18; and

(7) Nurses shall be registered as required by RSA 326-B:6 and have a master's degree in psychiatric nursing or be licensed as an advanced registered nurse practitioner (ARNP) with a psychiatric mental health specialty in accordance with RSA 326-B:11.

(i) Except as provided pursuant to (k) and (m) below, anyone providing psychotherapy services who does not meet the established standards as indicated in (h) above shall:

(1) Have completed at least one year of work in the field of psychiatric or mental health services under the supervision of a psychiatrist, doctoral level psychologist or a licensed mental health professional or person authorized pursuant to RSA 330-A:34, I, (d); and

(2) Have at least a master's degree in marriage and family therapy, psychology, social work, rehabilitation counseling or education/counseling from a college or university accredited by an accrediting agency recognized by the U.S. Department of Education; or

(3) Be a registered nurse with a certificate in mental health nursing from the American Nurse's Association.

(j) Persons who qualify to provide psychotherapy pursuant to (i) above shall have ongoing supervision of at least 2 hours per month. There shall be direct individual or group supervision of at least one hour per month by a licensed practitioner of the healing arts. The second hour may be peer review or case review, such as client-centered conferences. Direct supervision shall occur when the supervisor meets with the clinician to review his or her clinical practice in order to evaluate his or her performance.

(k) Individuals who are enrolled in formal internships in a professional field of study of mental health services and provide psychotherapy services shall:

(1) Be enrolled in at least a master's degree program in psychology, social work, rehabilitation counseling, education/counseling, or nursing at a college or university accredited by an accrediting agency recognized by the U.S. Department of Education; or

(2) Be enrolled in a doctoral or post doctoral program at a college or university accredited in psychology by an accrediting agency recognized by the U.S. Department of Education.

(l) Persons providing psychotherapy pursuant to (k) above shall receive direct supervision of at least one hour per week from a licensed practitioner of the healing arts, appropriate to the intern's field of study. The medicaid program shall reimburse CMHPs and community mental health providers only when supervision occurs and is documented. Direct supervision shall occur when the supervisor meets with the intern to review his or her clinical practice in order to evaluate his or her performance. The supervisor shall write and sign a weekly note in the intern's supervisory record stating his or her observations and recommendations relative to the intern's performance, and a monthly note summarizing his or her evaluation.

(m) Pursuant to RSA 135-C:3, persons providing medicaid reimbursed psychotherapy services in approved CMHPs prior to July 1, 1987, the initial effective date of He-M 426, shall be considered to have met the standards for other providers of psychotherapy set forth in (i) above and shall be supervised in accordance with the applicable requirements in (j) above.

He-M 426.09 Emergency Services.

- (a) Emergency services shall be:
 - (1) Covered CMHP services;
 - (2) Face to face interventions for the purposes of:
 - a. Reducing a recipient's acute psychiatric symptoms;
 - b. Reducing the likelihood of the recipient harming self or others; or
 - c. Assisting the recipient to return to his or her pre-crisis level of functioning; and
 - (3) Conducted with the therapist in direct, personal, involvement with the recipient to the exclusion of other recipients and duties.
- (b) Emergency services shall be available 24 hours a day, 7 days per week and be accessible to clients anywhere in the region served by the CMHP.
- (c) As follow-up to the initial emergency response, a client shall be eligible to receive a maximum of 5 emergency service sessions, consisting of not more than 6 15-minute units per session, for the purpose of stabilization of the emergency situation prior to intake or referral to another service or agency.
- (d) Emergency services shall be billed in 15-minute units, and shall be limited to 6 units per recipient per day to a maximum of 6 sessions per period of acute psychiatric crisis.
- (e) Emergency services shall be provided by staff of discrete emergency services programs or other staff serving as part of a formalized emergency services rotation.
- (f) Emergency assessment shall be provided for the purpose of emergency evaluation for hospital placement, crisis respite care, revocation of conditional discharge or other out-of-home placement.
- (g) The providers of emergency assessment shall meet the qualifications established in He-M 426.08(h)-(m).

He-M 426.10 Evaluations and Testing.

- (a) Psychiatric diagnostic interview exam shall include:
 - (1) History of present illness;
 - (2) Mental status examination; and
 - (3) Disposition.
- (b) Psychiatric diagnostic interview exam shall:
 - (1) Be a covered CMHP service when conducted by staff meeting qualifications as outlined in He-M 426.08(h)-(i);
 - (2) Be billed for the initial intake service;

- (3) Be billed as one event; and
 - (4) Be billed in accordance with current procedural terminology.
- (c) Evaluation and management shall include:
 - (1) History of present illness;
 - (2) Examination; and
 - (3) Medical decision-making.
- (d) Evaluation and management shall:
 - (1) Be a covered CMHP service;
 - (2) Be billed as one event; and
 - (3) Be billed in accordance with current procedural terminology.
- (e) Psychological testing shall be a covered CMHP service and consist of psychometric or projective tests, or both, with a written report. This procedure shall be billed per hour and be limited to 6 hours per recipient per 6 month period. Only persons licensed by state statute to provide psychological services shall provide this service.
- (f) Neuropsychological tests shall be evaluations that are:
 - (1) Designed to determine the functional consequences of known or suspected brain injury through testing of the neurocognitive domains responsible for language, including:
 - a. Perception;
 - b. Memory;
 - c. Language;
 - d. Problem solving;
 - e. Adaptation; and
 - f. Constructional praxis; and
 - (2) Carried out on persons who have suffered neurocognitive effects of medical disorders that impinge directly or indirectly on the brain.
- (g) Neuropsychological tests shall be billed per hour and be limited to 6 hours per recipient per 6 month period. Only persons licensed by state statute to provide psychological services shall provide this service.
- (h) PASARR evaluations shall be covered CMHP services and include psychiatric evaluations and related services to determine appropriateness for nursing home placement.

He-M 426.11 Partial Hospitalization Services.

(a) Partial hospitalization shall be a covered service and shall consist of intensive partial hospitalization services and restorative partial hospitalization services as described in (e) and (f) below.

(b) Only clients certified to receive long-term care services pursuant to He-M 426.18 shall be eligible for partial hospitalization services.

(c) Programs shall operate a minimum of 6 hours per day on weekdays and 4 hours per day on holidays and weekends for each day for which services are billed.

(d) Billing for partial hospitalization services shall be in half day or full day units, as follows:

(1) One half day of partial hospitalization shall be attendance at staff directed programs for at least 2 and less than 3 hours; and

(2) A full day of partial hospitalization shall be attendance at staff directed programs for 3 or more hours.

(e) Intensive partial hospitalization services shall be provided as follows:

(1) Placement into intensive partial hospitalization shall be made only with a written order from a psychiatrist, and be based on symptoms affecting the recipient's ability to function adequately in a community setting;

(2) Intensive partial hospitalization shall be offered no fewer than 5 days per week and be designed to provide short-term, structured, and active treatments which are problem-solving in nature and which are directed toward full or partial recovery from the prevailing crisis and the return of the recipient to a pre-crisis level of functioning;

(3) The provision of intensive partial hospitalization services shall be based on identified recipient needs as documented in the recipient's ISP;

(4) Intensive partial hospitalization services shall include:

a. Individual or group psychotherapy;

b. Psychological evaluations and testing;

c. Medication monitoring, evaluation, administration and education;

d. Clinical assessments to assist in individual service planning;

e. Family or significant other psychotherapy; and

f. Psychologically supportive individual or group activities;

(5) The daily services and activities of an intensive partial hospitalization program shall consist of:

- a. A minimum of 2 hours per day of any combination of activities contained in (e)(4)a. - e. above; and
 - b. The remainder of the day may consist of activities contained in (e)(4)f. above;
- (6) Participation in this program shall not exceed 20 treatment days per acute episode without a written order from a psychiatrist and a documented service plan review; and
- (7) There shall be no reimbursement from medicaid for any treatment exceeding 30 days per episode, or 90 days per state fiscal year.
- (f) Restorative partial hospitalization shall be provided as follows:
 - (1) Services shall encourage the development of those skills necessary for transfer to a variety of community living environments, including employment settings, and, as much as possible, reduce a recipient's dependency on state or federally funded programs while enabling the recipient to become a productive member of society, earn a wage, and live as independently as possible;
 - (2) Placement and participation in restorative partial hospitalization services shall be based on the needs of the recipient as documented in the ISP and functional deficits identified in the eligibility determination process pursuant to He-M 401;
 - (3) Restorative treatment shall:
 - a. Promote emotional, behavioral or psychological change;
 - b. Minimize the effects of mental disorders;
 - c. Promote health maintenance through clinical activities which foster the reduction of psychological stress;
 - d. Promote independent living;
 - e. Help maintain the client in a community setting;
 - f. Teach skills necessary for a client to function in the environments in which he or she lives and works; and
 - g. Utilize accepted principles of psychosocial rehabilitation;
 - (4) Restorative partial hospitalization services shall consist of the following components:
 - a. A comprehensive identification of the recipient's skills, strengths, and deficits in relation to the skill demands and supports required in the particular environment in which the recipient wants or needs to function, as such environment is consistent with the goals listed in the client's ISP;
 - b. Active recipient involvement which requires that assessment and intervention procedures be explained to and understood by the recipient;

- c. Teaching of skills necessary for the recipient to succeed in his or her chosen environments;
- d. A crisis management plan which shall serve to avert crises or mobilize resources rapidly to respond to crises and be implemented by intensive partial hospitalization services staff, emergency services staff or other appropriate staff within the CMHP; and
- e. Case management to assure linkage with all necessary services and people involved in the recipients' care, coordinated service planning, and monitoring of progress toward goals;

(5) Restorative partial hospitalization services shall include the following services:

- a. Individual or group counseling and psychotherapy;
- b. Medication monitoring, evaluation, administration and education;
- c. Family or significant other services, counseling and psychotherapy;
- d. Teaching daily living skills, community living skills and self-care skills;
- e. Nutritional services;
- f. Basic education;
- g. Recreational services;
- h. Psychological evaluations and testing; and
- i. Psychologically supportive individual or group activities;

(6) Recreational activities such as bowling, swimming and field trips shall be billable only when they are adjunct to, but not the only component of, the restorative partial hospitalization service; and

(7) Medicaid reimbursement for restorative partial hospitalization services shall not be made for a recipient for any day in which the recipient receives fewer than 2 hours of service, exclusive of recreational activities, unless in a given week the average per day participation in non-recreational activities exceeds 2 hours per day of service to the recipient.

(g) In addition to requirements listed in (e) and (f) above, reimbursement criteria for intensive and restorative partial hospitalization services shall include the following:

(1) Out-of-facility activities shall be covered under the following circumstances:

- a. The activities shall be directed by the partial hospitalization staff as part of a program based in the CMHP; and
- b. Stipends shall not be paid to recipients of partial hospitalization services in connection with the activities;

- (2) The medicaid rate for partial hospitalization shall be all inclusive;
- (3) On a day that a recipient receives partial hospitalization services, no reimbursement for other covered services shall be made except as allowed in (4) below;
- (4) The following services shall be reimbursable on any day that a recipient receives partial hospitalization services:
 - a. Case management services when provided under an approved case management option of the medicaid program;
 - b. Emergency visits if they occur outside of the normal operating hours of the partial hospitalization program;
 - c. Services provided by a continuous treatment team;
 - d. Individualized resiliency and recovery oriented services;
 - e. Medication checks for clozaril/clozapine management; and
 - f. Psychiatric evaluation for medicaid eligibility;
- (5) Services provided on a day the recipient did not attend partial hospitalization shall be billed in the normal manner for the service; and
- (6) Reimbursement for partial hospitalization services shall be limited to services for outpatients.
- (h) Staff who provide partial hospitalization services shall meet the following criteria:
 - (1) A partial hospitalization program shall employ a partial hospitalization supervisor who performs the following duties:
 - a. Supervises all staff of the partial hospitalization program;
 - b. Provides program administration; and
 - c. Ensures partial hospitalization services are coordinated with other services to assure continuity of recipient service; and
 - (2) The supervisor of partial hospitalization services shall minimally have:
 - a. Full time employment equaling 3 years' experience in programs for persons with long term mental illness;
 - b. One year of supervisory, management or administrative experience; and
 - c. A baccalaureate degree in social work, rehabilitation, psychology, education or a related human services field.
- (i) Each staff person providing partial hospitalization services shall at a minimum have:

(1) Either:

- a. A baccalaureate degree in social work, rehabilitation, psychology, education, or a related human services field; or
- b. An associate's degree in social work, rehabilitation, psychology, education, or a related human services field and the following experience:
 1. Two years of experience working with persons who have severe mental disability; or
 2. Two years of experience that provides an individual with an understanding of mental illness and that was acquired as an adult in the provision of significant supports to persons with mental illness, including the experience acquired by family members of persons with mental illness or by other persons who have personal knowledge of mental illness; and

(2) Completed the training curriculum based on the Illness Management and Recovery Implementation Resource Kit (DMSIMR001 edition) developed by Dartmouth Medical School if the staff will provide IMR services.

Readopt He-M 426.15 through He-M 426.23, effective 9-30-08 (Document #9285), to read as follows:

He-M 426.15 Case Management Services.

(a) Case management shall:

- (1) Assist clients eligible under the state plan in gaining access to needed medical, social, educational, and other services, on a one to one basis only;
- (2) Be a covered CMHP service;
- (3) Consist of at least one direct contact, either face-to-face or by telephone, with the client or guardian within every 90 days;
- (4) Be documented in the clinical record, including:
 - a. Whether the goals specified in the care plan have been achieved;
 - b. Whether the individual has declined services in the care plan;
 - c. Timelines for providing services and reassessment; and
 - d. The need for, and occurrences of, coordination with case managers of other programs.
- (5) For each event, the documentation shall include:
 - a. The name of the individual;
 - b. The dates of case management service;

- c. The name of the provider agency;
 - d. The nature, content, and units of case management service received, including, for units:
 - 1. The start time and duration of each event; or
 - 2. The start and stop time for each event; and
 - e. The signature of the person who provided the service.
- (6) Be billed only by the agency that is the primary service provider for individuals who receive services from both the behavioral health and developmental services systems.
- (b) The primary service provider shall be:
- (1) The agency that provides the greater dollar value of services to the individual; or
 - (2) The agency chosen by the consumer to provide case management subject to the following:
 - a. Persons who are conditionally discharged from a designated receiving facility in accordance with He-M 609 shall be considered eligible for a case manager from the behavioral health system in addition to a case manager from the developmental services system in cases where the developmental services system is the primary service provider;
 - b. Pursuant to He-M 426.23, providers may, with the consent of the consumer, request a waiver from He-M 426.15(a)(6) to enable consumers to receive case management by both systems; and
 - c. The commissioner shall grant a waiver if a review of the person's clinical condition establishes that the person has symptoms that are acute or severe and that require multiple services from the secondary service provider.
- (c) Case management services shall be limited to the following:
- (1) Assessment and periodic reassessment of an eligible individual to determine service needs, including the following activities:
 - a. Taking client history;
 - b. Gathering information from other sources such as family members, medical providers, social workers and educators, if necessary, to form a complete assessment of the eligible individual;
 - c. Assessing the individual's strengths; and
 - d. Determining the individual's preferences;
 - (2) The assessment shall determine the need for the following services:
 - a. Medical services including, but not limited to, primary care, dental care, home health care and assistance with activities of daily living (ADL);

b. Educational services including, but not limited to, obtaining high school or advanced degrees, skill-building classes, parenting education and other support groups;

c. Social services including, but not limited to, employment, housing and transportation; and

d. Other services, including but not limited to, opportunities for personal development, maintenance and support of social and familial relationships and the pursuit of hobbies and interests such as spiritual development;

(3) Development and periodic revision of a specific and comprehensive care plan based on the information collected through an assessment or reassessment that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual shall be in place no later than April 1, 2009. An individual may decline to receive services in the care plan;

(4) Referral and related activities to help an individual obtain needed services, such as scheduling appointments, but not including transportation, escort, and childcare services; and

(5) Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Monitoring should occur no less frequently than annually.

(d) A client shall be eligible to receive case management services when:

(1) Services are delivered in accordance with an ISP; and

(2) The individual is:

a. A severely mentally disabled person who is eligible to receive department-funded services pursuant to He-M 401; or

b. A family member of a person who is eligible for long-term care as defined in He-M 426.02(v) and is under age 18.

(e) Case management services for an individual who has been admitted to a hospital or nursing facility shall include:

(1) Providing ongoing case management services on behalf of the client in order to ensure that services and supports are established and maintained within the community and within the community mental health system;

(2) Establishing and maintaining contact with community agencies and individuals to develop community resources, to foster access to services other than those offered through the state mental health system, and to encourage community support to the client when he or she returns to the community;

(3) Arranging, in collaboration with the hospital or nursing facility, community supports appropriate to the client's need;

(4) Participating in the service planning process, from initial treatment planning through discharge planning, and supporting the participation of the client, the family, and the guardian in the treatment planning process and, with the client's or guardian's consent, involving significant others;

(5) Providing information necessary for individual service planning, with the consent of the client, pursuant to He-M 408;

(6) Participating in making discharge plans and in securing access to available community resources of choice in order to foster a smooth transition to the community; and

(7) After a client's involuntary commitment and conditional discharge pursuant to He-M 609, advising the administrators of the CMHP or provider and the hospital concerning the client's progress with, and suggesting revisions in, the discharge conditions.

(f) Transitional case management shall:

(1) Be provided to individuals, under the age of 22 and over the age of 64, who are transitioning from a hospital or nursing facility to the community;

(2) Be a covered service during the last 180 consecutive days of a medicaid eligible person's institutional stay if provided for the purpose of community transition; and

(3) Be billed if the following conditions are met:

a. The individual has been discharged from the hospital or nursing facility;

b. The individual is enrolled with the community case management provider; and

c. The individual is receiving medically necessary services in a community setting.

(g) Case managers shall not exercise the state agency's authority to authorize or deny the provision of other services under the state plan.

(h) All staff providing case management services shall be supervised in accordance with the requirements contained in He-M 426.13(a) relative to supervision of staff providing functional support services.

(i) Each staff person providing case management services shall meet the requirements contained in He-M 426.13(b) and (d) relative to requirements for staff providing functional support services.

He-M 426.16 Services Not Otherwise Classified.

(a) The invoice for services not otherwise classified in this rule shall be accompanied by a statement describing the service including the following:

(1) The name of the recipient receiving the service(s);

(2) The type, frequency, and duration of the service(s);

(3) The name, title, and professional qualifications of the person(s) providing the service(s); and

(4) The reason(s) why the service(s) was provided, which shall include reference to the recipient's ISP.

(b) Services not otherwise classified shall be:

(1) Designed to meet a specific need identified in a recipient's ISP; and

(2) Allowed by federal requirements.

He-M 426.17 Documentation. Clinical information and documentation of services as required by He-M 408 shall be maintained by the CMHP or community mental health provider.

He-M 426.18 Medicaid Payment for Long-Term Care Certification.

(a) Except for those medicaid recipients eligible to receive early and periodic screening, diagnosis and treatment (EPSDT) pursuant to He-W 546 or eligible to receive long-term care services in accordance with (b) below, the Medicaid payment limit per fiscal year for all community mental health services shall be the limit established by the commissioner with approval of the US Department of Health and Human Services Centers for Medicare and Medicaid Services as an amendment to the Title XIX State Plan in accordance with He-W 520.02 and Section 1902(a) of the Social Security Act. The fiscal year runs from July 1 to June 30. Individual service limits shall still apply.

(b) A client shall qualify for services in excess of the annual medicaid payment limit if that client has been certified for long-term care services by:

(1) Determination by the CMHP that the client is eligible to receive department funded services pursuant to He-M 401; or

(2) Determination by a CMHP that a child through age 17 is eligible for services pursuant to He-M 401 unless the psychiatrist has approved the child to remain until age 21 in a children's program pursuant to He-M 401.

(c) The department shall recover any medicaid payments in excess of the medicaid payment limit per state fiscal year for a recipient under each of the following circumstances:

(1) The recipient's record lacks a properly completed eligibility statement which covers long-term care services billed for the period under review;

(2) The eligibility period has expired and the redetermination of eligibility has not been completed;

(3) Documentation in the clinical record fails to substantiate that the recipient meets the criteria for certification for long-term care; and

(4) The recipient's diagnosis does not meet the criteria in He-M 401.

(d) Certifications made pursuant to (b)(1) above and dated later than the service period being billed for shall be invalid.

(e) For individuals eligible as adults with severe or severe and persistent mental illness with low service utilization pursuant to He-M 401.07, the commissioner shall establish a limit on the payment for services per state fiscal year. The limit shall be subject to approval by the US Department of Health and Human Services Centers for Medicare and Medicaid Services as an amendment to the Title XIX State Plan in accordance with He-W 520.02 and Section 1902(a) of the Social Security Act. The annual limit shall be waived if the standards established by He-M 426.23 are met.

(f) Mental health assessment by a non-physician for the purpose of determining long-term care eligibility shall be a covered service when performed by individuals meeting the qualifications in He-M 401.04(b).

(g) Comprehensive geriatric assessment and treatment planning performed by assessment team for the purpose of determining long-term care eligibility shall be a covered service when performed by individuals meeting the qualifications in He-M 401.04(b).

He-M 426.19 Fair Hearings. Any medicaid recipient who has been found ineligible for long-term care services by the CMHP or community mental health provider may appeal the adverse decision by requesting a fair hearing in accordance with He-C 200. Complaints regarding provision of services may be filed in accordance with He-M 401.14, He-M 309, and He-M 204

He-M 426.20 Revocation of Approval as a Community Mental Health Provider.

(a) Approval as a community mental health provider shall be revoked, following written notice pursuant to (b)(2) below and opportunity for a hearing pursuant to He-C 200, due to:

- (1) Failure of the provider to comply with this rule or any other applicable rule promulgated by the department;
- (2) The provider failing to provide information requested by the department and required pursuant to chapter He-M 400 or knowingly giving false or misleading information to the department;
- (3) Refusal by the provider to admit any employee of the department authorized to monitor or inspect the provider's services and programs;
- (4) Any reported abuse, neglect, or exploitation of clients by a provider's staff if:
 - a. Such personnel have not been prevented from having contact with clients as of the reporting date of the alleged violation; and
 - b. Such abuse, neglect, or exploitation is founded based on a protective investigation performed by the department in accordance with He-E 700 and an administrative hearing held pursuant to He-E 200, if such a hearing is requested;
- (5) Revocation of licensure or denial of application for licensure pursuant to RSA 151; or
- (6) Revocation of certification pursuant to He-M 1002.

(b) Revocation of approval shall be in accordance with the following:

- (1) Upon determination that a provider meets any of the criteria for revocation listed in (a) above, the commissioner shall revoke the approval of the provider;
- (2) Revocation shall only occur following:
 - a. The provision of 30 days' written notice by the commissioner to the provider stating the reason(s) for the revocation and, if applicable, the specific rule(s) with which the provider is alleged to not comply; and
 - b. Opportunity for a hearing on the decision pursuant to He-C 200, if requested by the provider;
- (3) The commissioner shall withdraw a notice of revocation if, within the notice period, the provider takes corrective action resulting in the elimination of the reason(s) for revocation; and
- (4) Pending corrective action by the provider eliminating the reason(s) for revocation, a provider shall not accept additional clients if a notice of revocation has been issued concerning a violation which presents potential danger to the health or safety of the clients being served.

He-M 426.21 Suspension of Approval.

- (a) In the event that a violation poses an immediate and serious threat to the health or safety of the clients, the commissioner shall suspend a provider's approval immediately upon issuance of written notice specifying the reasons for the action.
- (b) In the event that the commissioner suspends the approval of a provider, the suspension shall be effective from the date that the violation occurred until such time as the commissioner determines that the provider is in compliance with all applicable rules adopted by the commissioner and no longer poses an immediate and serious threat to the health or safety of the clients served by the provider.
- (c) At the time that the commissioner suspends the approval of a provider, the commissioner or his or her designee shall schedule a hearing to be held within 10 working days, in accordance with He-C 204.
- (d) A hearing held pursuant to (c) above shall:
 - (1) Have as its purpose determination of whether the provider in fact posed an immediate and serious threat to the health and safety of its clients at the time its approval was suspended; and
 - (2) Afford the provider an opportunity to show that:
 - a. Since the time that its approval was suspended it has come into compliance with all applicable rules promulgated by the department and no longer poses an immediate and serious threat to the health or safety of its clients; or
 - b. It had never been out of compliance or had never posed an immediate and serious threat to the health or safety of its clients.

He-M 426.22 Payment.

(a) Medicaid payments shall be made for CMHP services rendered to recipients with both psychiatric and mental retardation diagnoses for services related to the psychiatric diagnosis. Medical and billing records shall support this classification. The claim shall indicate the primary diagnosis related to the service rendered.

(b) Community mental health services shall be paid at rates set by the department based on the audited costs of covered services as determined by units of services provided by all community mental health providers divided by the sum of costs for client transportation, staff and staff related costs to provide such services incurred by all community mental health providers.

(c) Claims for medicare-eligible medicaid recipients shall be submitted to medicare for all medicare covered services prior to submitting claims to medicaid.

(d) Except for claims for people not eligible for medicaid, claims for service shall be submitted to the fiscal agent designated by the department.

(e) Claims for services necessary to determine the appropriateness of nursing home referral, PASARR, for people who are not eligible for medicaid shall be submitted to:

NH Department of Health and Human Services
Behavioral Health
PASARR Office
105 Pleasant Street
Concord, NH 03301

He-M 426.23 Waivers.

(a) A CMHP or community mental health provider may request a waiver of specific procedures outlined in this part, in writing, from the department.

(b) A request for a waiver shall include:

- (1) A specific reference to the section of the rule for which a waiver is being sought;
- (2) A full description of why a waiver is necessary; and
- (3) A full explanation of alternative provisions or procedures proposed by the CMHP or community mental health provider.

(c) No provision or procedure prescribed by statute shall be waived.

(d) A request for a waiver shall be granted after the commissioner or his or her designee determines that the alternative proposed by the CMHP or community mental health provider meets the objective or intent of the rule and:

- (1) Does not negatively impact the health or safety of recipients; and
- (2) Does not affect the quality of CMHP or community mental health provider services.

(e) Upon receipt of approval of a waiver request, the CMHP's or community mental health provider's subsequent compliance with the alternative provisions or procedures approved in the waiver shall be considered compliance with the rule for which the waiver was sought.

(f) Waivers shall be granted in writing for a specific duration not to exceed 5 years except as in (g) below.

(g) Those waivers which relate to the following shall be effective for the CMHP's or community mental health provider's current certification period only:

(1) Fire safety; or

(2) Other issues relative to consumer health, safety or welfare that require periodic reassessment.

(h) A CMHP or community mental health provider may request a renewal of a waiver from the department. Such request shall be made at least 30 days prior to the expiration of a current waiver.

Appendix

| Rule | State or Federal Statutes the Rule Implements |
|----------------------|--|
| He-M 426.01 – 426.23 | RSA 135-C:1; RSA 135-C:57 |